Department of Health Services

(*FORM NUMBER 1*) AB 2877 WAGE PASS-THROUGH (WPT) CERTIFICATION FORM

1. Legal Name of Facility **1.(a) D.B.A. (doing business as)**	**2. Medi-Cal Provider No.**
3. Level of Service	**4. Facility Phone No.**
5. Facility Street Address	**6. City & State** **7. Zip**
8. Mailing Address (if different)	**9. City & State** **10. Zip**
11. Administrator or Contact Person	**12. Phone No.**
13. Name of Related Organization	**14. Contact Person** **15. Phone No.**
16. Address of Related Organization	**17. City & State** **18. Zip**

19. Bargaining Agents if applicable (Agents Name & Addresses)

Registered Nurses (RN):
Licensed Vocational Nurses (LVN):
Nurse Assistants (NA):
Respiratory Care Employees (Pediatric Subacute Facilities):
Linen and Laundry Staff:
Plant Operations and Maintenance Staff:
Housekeeping Staff:
Dietary Staff:
Qualified Mental Retardation Professionals:(ICF/DDs,ICF/DD-Hs,ICF/DD-Ns):
Nonsupervisory direct care staff:(ICF/DDs,ICF/DD-Hs,ICF/DD-Ns):

20. Facility Fiscal Period Ending During August 1, 2000 through July 31, 2001

CERTIFICATION

I, the undersigned, state that as a facility Administrator, owner, officer or other individual duly authorized in a resolution by this facility's Board of Directors as having authority to sign on behalf of this facility, I am authorized and designated to make this certification for and on behalf of _____(name of facility), that the WPT certification documents attached hereto are true to my knowledge and that the facility has expended the funds as indicated in the documents attached. I declare that the certification information is true and correct. I understand that the making of false statements or the filing of false or fraudulent claims is punishable under Welfare and Institutions Code Sections 14107, 14107.11, and other applicable provisions of law. In the event of a change of ownership of the facility, certified copies of the records will be delivered to the new owners at the time of the transfer of the facility and written notification to the Department of Health Services will be made reporting the records transfer.

Executed on _____(date) at _____(place)
_____(Signature)
_____(Title)
_____(Printed Name)

It should be noted that these forms will be used as a mechanism to demonstrate compliance which is only one aspect of the certification process. Facilities may also be subject to field review of WPT compliance. This field review will utilize facility books and records and may be independent of the certification forms included in this package. If a facility is determined to be out of compliance with the provisions of Welfare and Institutions Code, Sections 14107 and/or 14110.6, such facility is liable to make restitution to the Medi-Cal program of any funds not expended for this purpose and to pay a penalty equal to 10 percent of any funds not expended.

Forward a copy of this WPT certification form and the certification worksheets to the appropriate bargaining agents listed on line 19 above, if applicable.

Mail two copies of the WPT certification form and worksheet, for each level of care provided by your facility, to the address below by November 1, 2001.

State of California Department of Health Services
Audits and Investigations
Financial Audits Branch
Audit Review and Analysis Section
Attention: WPT Coordinator
591 North 7th Street
P.O. Box 942732
Sacramento, CA 94234-7320

Note: * Any questions regarding this certification should be submitted in writing to the address listed above or e-mailed to the following: aiwpt@dhs.ca.gov

RETURN THIS FORM TO THE DEPARTMENT